DEPARTMENT OF MANAGED HEALTH CARE
CALIFORNIA HMO HELP CENTER
DIVISION OF PLAN SURVEYS

MENTAL HEALTH PARITY FOCUSED SURVEY REPORT

CIGNA HealthCare of California, Inc.

CIGNA Behavioral Health of California, Inc.

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EXECUTIVE SUMMARY

The California Department of Managed Health Care (the "Department") conducted a Focused Survey of CIGNA HealthCare of California, Inc., (the "Plan") and CIGNA Behavioral Health of California, Inc., (the "Delegate") from May 23, 2005, to May 26, 2005. A "focused survey" assesses compliance of a particular aspect of plan operations with the Knox-Keene Health Care Service Plan Act of 1975 ("Knox-Keene"). In this case, the Focused Survey assessed compliance of the Plan's delivery of mental health services (Section 1374.72 of the Health and Safety Code, Severe mental illnesses; serious emotional disturbances of children).

CIGNA HealthCare of California was the sixth of seven focused surveys completed between March and June 2005. Plans that were surveyed are Knox-Keene licensed full-service plans, and if applicable, specialty mental health plan delegates that administer and provide mental health benefits and services on behalf of the full-service plan.

Health and Safety Code Section 1374.72, often referred to as the "**Parity Act**," requires full-service health plans to provide coverage for the diagnosis and treatment of severe mental illnesses of a person of any age, and of serious emotional disturbances of a child, under the same terms and conditions applied to other medical conditions. Rule 1300.74.72 requires health plans to provide timely access and referral for the diagnosis and treatment of conditions set forth in Section 1374.72. The Rule also requires full-service health plans that contract with specialty mental health plans for the provision of mental health services to monitor the collaboration between the two contracting plans and to ensure the continuity and coordination of care provided to enrollees.

The Plan delegates the provision of mental health services to CIGNA Behavioral Health of California, Inc. The Delegate provides mental health services to 75 percent of Plan enrollees. The remaining 25 percent receive mental health services from more than 12 managed behavioral health plans as a result of arrangements that employers have made with these plans. (See Appendix B)

Background

CIGNA HealthCare of California, Inc.,

CIGNA HealthCare of California has its origins in several plans in California. In 1978, the Insurance Company of North America (INA) acquired the California Medical Group and the California Medical Group Health Plan through its subsidiary INA Health Plan, Inc. In 1980, INA HealthPlan acquired the Ross-Loos Medical Group, a staff-model HMO that had been founded by Drs. Ross and Loos in 1929 to provide medical services for the Los Angeles Department of Water and Power, and HMO International and its subsidiaries, including California Medical Group and its Health Plan.

In 1982, INA Corporation merged with Connecticut General Life Insurance Company, forming CIGNA. In 1984, INA HealthPlan became CIGNA HealthPlans of California and the Ross-Loos

Health Plan continued operations under the CIGNA name. CIGNA HealthCare of San Diego began operations serving San Diego County.

In 1985, CIGNA Private Practice Plan, an IPA-model HMO, began operations in California. In 1993, the parent corporation's name was changed to CIGNA HealthCare of California, Inc., with markets in Southern California, Northern California, and San Diego. In 1995, the merger of CIGNA HealthCare of California, Inc., and Ross-Loos HealthPlan, Inc. left CIGNA HealthCare of California, Inc., as the holder of the Knox-Keene license.

In 1999 the Southern California, Northern California, and San Diego markets consolidated into one statewide organization, CIGNA HealthCare of California, Inc. CIGNA HealthCare of California, Inc., currently has a Excellent rating from NCQA for its HMO and POS products.

CIGNA HealthCare of California is a wholly owned subsidiary of Healthsource, Inc., which is a wholly owned subsidiary of CIGNA Health Corporation, which is a wholly owned subsidiary of the Connecticut General Corporation, which is a wholly owned subsidiary of CIGNA Holdings, Inc., which is a wholly owned subsidiary of CIGNA Corporation.

CIGNA Behavioral Health of California, Inc.,

CIGNA Behavioral Health of California, Inc., is the successor company to MCC Behavioral Care of California, Inc., which CIGNA acquired in the early 1990s. MCC obtained its Knox-Keene license on August 1, 1990. The Department approved the Plan's name change to CIGNA Behavioral Health of California, Inc., in November 1999.

CIGNA Behavioral Health of California, Inc., is a wholly owned subsidiary of Connecticut General Corporation, which is a wholly owned subsidiary of CIGNA Investment Group, which is a wholly subsidiary of CIGNA Holdings, Inc., which is a wholly owned subsidiary of CIGNA Corporation.

Survey Results

As part of the Focused Survey, the Department assessed the Plan's operations in the following four major areas as they relate to the Parity Act: **Access and Availability of Services, Continuity and Coordination of Care, Utilization Management,** and **Delegation Management**.

The Department identified three compliance deficiencies in the Plan's implementation of and compliance with Section 1374.72. (See Section III, Table 1). One deficiency was found in the area of Access and Availability of Services and two deficiencies were found in the area of Utilization Management. Based on the review of the documents submitted by the Plan in its response, the Department has determined that the Plan has corrected all three of the deficiencies.

Please refer to Section III for a detailed discussion of the deficiencies, the Department's findings, required corrective actions, and the Plan's response and compliance efforts.

SECTION I. FOCUSED SURVEY BACKGROUND

The Department's authority to conduct surveys comes from Knox-Keene, which mandates that the Division of Plan Surveys ("Plan Surveys") conduct onsite medical surveys of all licensed health plans at least once every three (3) years, including full-service and specialized plans. Full-service health plans are defined as plans that provide all basic health care services. Specialized plans include behavioral health, vision, dental, and chiropractic plans.

In its planning for 2005, the Department's administration directed Plan Surveys to design focused surveys to review health plan compliance with enacted mental health parity laws. The project began in November 2004 and includes three phases:

(1) Stakeholder input, inclusive of several meetings held to gather comments and identify issues currently voiced in the mental health community;
(2) Operations component, included survey tool development and scheduling; and
(3) Conduct the surveys.

The Department supports continued discussions with stakeholders and will receive comments and suggestions throughout the project.

The purpose behind the focused surveys is to assess specific plan compliance and also to research some of the problems voiced by stakeholders, such as inadequate access to mental health providers and lack of payment of emergency mental health services. Meeting the challenges of implementation of the parity law from the health plan perspective was addressed with Plan management during the first day of the focused survey.

The Focused Survey Approach

Focused surveys give the Department the ability to swiftly respond to potentially serious health plan problems, concerns, or questions raised by consumers, legislators or other Department divisions on a particular issue. Focused surveys could include an assessment of compliance with newly enacted legislation such as the Parity Act or specific applications such as Diabetes supplies regulations.

Although Section 1374.72 is reviewed by the Department for compliance as part of the normal routine medical survey process, this focused survey approach allows a more detailed look at application and compliance.

SECTION II. SCOPE OF WORK

The subject of this Focused Survey is Health and Safety Code Section 1374. 72, Rule 1300.74.72, and other relevant sections of Knox-Keene, including but not limited to:

- Determining whether the plan and its contracted mental health plan have developed and maintained adequate provider networks to promote timely access to mental health services;
- Determining whether the plan and its contracted mental health plan are effectively coordinating the care of enrollees and providing continuity of care; and
- Determining whether the plan and its contracted mental health plans are authorizing and providing medically necessary services mandated under Section 1374.72 in an appropriate and timely manner.

Specifically, the Department assessed the Plan's operations in the following four major areas as they relate to the Parity Act:

- **Access and Availability of Services** – to determine whether the Plan designs benefits for parity diagnoses under the same terms and conditions applied to other medical conditions, clearly communicates those terms and conditions to enrollees, and has developed and maintained adequate provider networks to assure enrollees timely access and referral to mental health services.
- **Continuity and Coordination of Care** – to determine whether the Plan provides appropriate continuity and coordination of care for enrollees with parity diagnoses.
- **Utilization Management/ Benefit Coverage** – to determine whether the Plan appropriately authorizes and provides medically necessary treatment and services required under Section 1374.72 to enrollees with parity diagnoses.
- **Delegation Management** – when applicable, to determine whether the Plan adequately and appropriately oversees its contracted specialty mental health plan and ensures that parity mental health services are provided to enrollees with parity conditions in a timely and appropriate fashion, under the same terms and conditions applied to medical conditions.

SECTION III. SURVEY FINDINGS

The table below lists deficiencies identified during the Focused Survey. The Department issued a Preliminary Report to the Plan regarding these deficiencies on July 11, 2005. In the Report, the Plan was instructed to: (a) develop and implement a corrective action plan for each deficiency, and (b) provide the Department with evidence of the Plan's completion of or progress toward implementing those corrective actions. The "Status" column describes the Department's findings regarding the Plan's corrective actions.

TABLE 1: DEFICIENCIES

#	SUMMARY OF DEFICIENCIES	Status
ACCESS AND AVAILABILITY OF SERVICES		
1	**The Plan, via the Delegate personal advocates, does not clearly present the distinction and benefit differences between parity and non-parity conditions to enrollees who contact the Delegate for benefit information or to access services.** [Rule 1300.67.2(g), Rule 1300.74.72(g)]	Corrected
UTILIZATION MANAGEMENT		
2	**The Plan does not consistently include the direct telephone number or extension of the mental health professional who made the medical necessity denial determination in the denial decision notification that the Plan sends to the requesting provider. The Plan also does not include the name of the pharmacist or mental health professional who made the formulary exception denial determination in the denial decision notification that the Plan sends to the requesting provider.** [Section 1367.01(h)(4)]	Corrected
3	**The Plan incorrectly and inappropriately denies payment for emergency claims.** [Section 1371.4]	Corrected

The following details the Department's preliminary findings, the Plan's corrective actions and the Department's findings concerning the Plan's compliance efforts.

A. ACCESS AND AVAILABILITY OF SERVICES

Deficiency 1: The Plan, via its Delegate's Personal Advocates, does not clearly present the distinction and benefit differences between parity and non-parity conditions to members who contact the Plan for benefit information or to access services. [Rule 1300.67.29(g), Rule 1300.74.72 (g)]

Documents Reviewed:

- CBH Job Description: Senior Personal Advocate
- CIGNA Health Plan Member Handbook(s)

- Group Service Agreement(s)

Department Findings: Enrollees may call the Plan via the Delegate's telephone number listed on the member identification cards and speak to a personal advocate to confirm eligibility and to obtain mental health benefit information and provider referrals. For callers who appear emotionally stable, in minimal distress, and having uncomplicated treatment needs, the personal advocate may provide information for outpatient mental health services based on the enrollee's stated needs and requests. If the enrollee meets one or more of the Delegate's transfer criteria, which include reporting a parity qualifying diagnosis, having more complicated needs, presenting as emotionally distressed, or otherwise giving evidence of a serious mental illness in him/herself or in the person on whose behalf s/he is calling, the personal advocate transfers the enrollee to a licensed care manager for triage and referral.

The Department discussed the Delegate's call center procedures and how benefits are described with the Delegate's Quality Manager, Professional Relations Manager, Personal Advocate Manager, and Crisis Team Leader. The Department also interviewed a Personal Advocate Team member regarding exactly how advocates are trained to present benefit information to enrollees. The Delegate's procedures call for advocates to quote only non-parity benefits to members who call in with ostensibly uncomplicated needs. Typically Crisis Team members or other care managers are the only staff members who describe parity benefits to enrollees when conditions indicate that the enrollee may have a parity diagnosis.

Delegate staff members stated that their operating policy is to present parity benefit information only when prompted by caller's specific request or another indication that a parity-related condition is the focus of treatment. Staff reported that generally it is providers that specifically request parity benefit information.

Implications: Enrollees may not be aware of additional benefits available to individuals with parity diagnoses. To the extent that a person needs mental health treatment, information regarding the benefits and covered services is essential to avoid delays in obtaining care.

Corrective Action: The Plan shall provide evidence that its Delegate has revised its policies to require that personal advocates and care managers describe both parity and non-parity benefits clearly and accurately to enrollees inquiring about mental health benefits. Further, the Plan shall provide evidence that the Delegate has informed its personal advocates, care managers, and other staff who describe benefits to enrollees to present parity and non-parity benefit information correctly.

Plan's Compliance Effort: The Plan stated in its response the following:

To assure that there can be no question about the Plans' policy to clearly describe parity benefits to members needing this information, CIGNA Behavioral has amended its Personal Advocate policy to include the following:

> *J) The process Personal Advocates staff shall follow includes:*
>
> *11) Communicating information about parity and non-parity benefits clearly and accurately to members in accordance with the needs of members for such*

> *information. Also, communicating information about how to obtain mental health services for parity and non-parity conditions in accordance with the needs of members for such information.*

The Plans have communicated to their staff the auditors' concerns that members may not understand the expanded benefits available to individuals with a parity diagnosis and has emphasized the need to present parity and non-parity benefit information to any member that might have a need for that information."

The Plan submitted the following document:

- Revised Personal Advocate

Department's Finding Concerning Plan's Compliance Effort:

STATUS: CORRECTED

The Department finds that this deficiency has been fully corrected.

Nothing in the Discussion of Findings suggests that the Department requires that parity benefit description be given to all callers. However, if a caller inquires about mental health benefits, the Plan must disclose the availability of both parity and non-parity benefits.

B. UTILIZATION MANAGEMENT / BENEFIT COVERAGE

Deficiency 2: The Plan does not consistently include the direct telephone number or extension of the mental health professional who made the medical necessity denial determination in the denial decision notification that the Plan sends to the requesting provider. The Plan also does not include the name of the pharmacist or mental health professional who made the formulary exception denial determination in the denial decision notification that the Plan sends to the requesting provider. [Section 1367.01(h)(4)]

Documents Reviewed:

- Thirty-four medical necessity denial files during April 2004–March 2005
- Three psychotropic medication formulary exception denial files during April 2004–March 2005

Department Findings: The Department reviewed 34 Delegate medical necessity denial files and three Plan psychotropic medical formulary exception denial files. In 19 of these files, the denial notification letter sent to the requesting provider did not include the direct telephone number or extension of the mental health professional who made the determination. The Delegate's explanation for this was that the Delegate often uses CIGNA psychiatrist and psychologist utilization management reviewers not physically located at the Delegate's Glendale office. In these cases, the denial letter goes out over the name of a care manager. Although these letters cite the name of the psychiatrist or psychologist who made the adverse decision, they give only

the phone number of the Glendale office for the provider to call with any questions. They do not state explicitly that the mental health care professional making the adverse decision can be reached at the telephone number listed for the Glendale-based care manager, who transfers the call to the CIGNA office in which the peer reviewer is located.

In all three of the formulary exception denial notification letters that the Department reviewed, the Delegate did not provide the name of the pharmacist who made the denial decision in the body of the letter. Although the letter is signed by the pharmacist who made the denial determination, nothing in the text of the letter explains that the signing pharmacist made the decision. Furthermore, the letter offers the provider the opportunity "to discuss this decision with our pharmacist or physician," without specifically stating that the requesting provider can speak with the specific individual who made the denial decision.

TABLE 2: MEDICAL NECESSITY AND FORMULARY EXCEPTION DENIALS

FILE TYPE	# OF FILES REVIEWED	CRITERIA	# COMPLIANT	# DEFICIENT
Medical Necessity Denials	34	Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification.	15	19
Formulary Exception Denials	3		0	3

Implications: The lack of the name and/or telephone number of the provider that made the denial decision on the denial notification letter denies the requesting provider reasonable access to the Plan's UM decision maker to discuss denial decision and provide additional information, if available.

Corrective Action: The Plan shall submit evidence that the Delegate consistently includes the direct telephone number or extension of the mental health professional who made the medical necessity denial determination in the denial decision notification and has revised:

(1) The standard utilization management medical necessity denial letter to include the direct phone number of the peer reviewer who made the adverse decision;
(2) The standard pharmacy medication provider denial letter to provide the name and direct telephone number of the pharmacist who made the denial decision.

Plan's Compliance Effort: The Plan stated in its response the following:

A. CIGNA Behavioral Denial Letters

The Department's auditors determined that denial letters of CIGNA Behavioral were deficient because even though the letters identified name and title of the mental health professional

responsible for the adverse decision and provided a number for the requesting provider to call if the requesting provider had questions concerning the decision, the letter did not specifically reference that the mental health professional making the adverse decision could be reached at the number provided. In other words, the auditors were concerned that the requesting provider might be confused or misled into thinking that he or she could only contact the care manager with questions about the decision and not the mental health professional.

It has been the experience of CIGNA Behavioral that its providers have not been confused about whom to contact with questions about the adverse decision. Peer to peer discussions have occurred and continue to occur on a regular basis.

Notwithstanding the foregoing, CIGNA Behavioral desires to address the concerns of the auditors. Accordingly, CIGNA Behavioral has revised its denial letter to include the following paragraph:

> If you would like to discuss the outcome of this determination with the reviewing physician, please contact me at [insert direct phone number]. I would be happy to facilitate your request.

B. CIGNA HealthCare Pharmacy Service Center Denial Letters

As the Department noted in the Preliminary Report, all three of the formulary exception denial letters in the audit sample were signed by the pharmacist who made the denial decision. Although the Plan believes that providers clearly understand that the pharmacist who signed each letter is the health professional who made the adverse determination, the Plan has revised the introductory sentence of its Pharmacy Service Center Denial Letter templates as follows:.

> ~~We~~ I have reviewed your request to cover the drug shown above. Because the medical necessity criteria for this drug has not been met, ~~we~~ I have not authorized coverage on behalf of CIGNA HealthCare.

Furthermore, the Plan has revised the sentence that offers the provider the opportunity to discuss the decision with the pharmacist who made the decision as follows:

> If the physician would like to discuss this decision with ~~our pharmacist or physician~~ me or a consulting physician, please call [phone number].

The Plan submitted the following document:

- Revised Pharmacy Service center denial letter
- Revised denial letter

Department's Finding Concerning Plan's Compliance Effort:

STATUS: CORRECTED

The regulations are explicit in the requirement to provide a direct telephone number or extension

to a requesting provider to facilitate contact with the Plan professional responsible for the decision. The Department finds that this deficiency has been corrected.

Deficiency 3: The Plan incorrectly and inappropriately denies payment for emergency claims. [Section 1371.4]

Documents Reviewed:

- Emergency service claims covering the period from April 2004 to March 2005

Department Findings: Two types of diagnosis are considered by the Plan and the Delegate when processing ER claims:

(1) Admitting diagnosis – that for which a healthcare service is sought, sometimes referred to as the "chief complaint."

(2) Primary or principal diagnosis – the final diagnosis of the treating provider usually assigned by the treating provider on or before a patient's discharge from the ER, hospitalization or the provider's care. Claims commonly contain both admitting and primary/principal diagnoses as well as both mental health and medical diagnoses. For example, while the admitting diagnosis is "shortness of breath," the primary or principal diagnosis may be "anxiety disorder." In this example, the former is a medical diagnosis and the latter is a mental health parity diagnosis.

The Delegate is financially responsible for all claims with any admitting mental health diagnosis (regardless of parity, service, or provider.) The admitting diagnosis determines whether the Plan or Delegate is ultimately responsible for the claim. If a claim does not have an admitting diagnosis, the examiner will call the provider to obtain either the admitting diagnosis or the chief complaint. If information is not obtained, a letter is sent to the provider following the telephone call. Two letters are sent prior to the final and third letter, which notifies the provider that the claim is denied due to non-receipt of requested information. Examiners should disregard the principal diagnosis, even if such diagnosis is mental health. The enrollee is not apprised of the status of the claim.

The Plan, on the other hand, is financially responsible for all claims with an admitting medical diagnosis or with a principal medical diagnosis. If the admitting diagnosis is mental health and the principal diagnosis is medical, it denies the claim as Delegate's responsibility and forwards the claim to the Delegate by mail. However, if the admitting diagnosis is missing, the Plan's examiner may default to the principal diagnosis. If the principal diagnosis is mental health, the Plan forwards the claim to the Delegate. If the principal diagnosis is medical, the Plan pays the claim.

Of 53 denied ER claims that the Plan submitted from April 2004 to March 2005, only three had an admitting parity diagnosis. The Department randomly selected an additional 27 claims for a total of 30 ER mental health claims, and further narrowed its sample by choosing only those claims with an admitting or principal parity diagnosis. The final selection yielded 12 claims:

three with an admitting diagnosis of parity and nine with a principal diagnosis of parity. Of the 12, only one was from a participating provider and none was from a county facility. The Department found that eight of the 12 ER claims were inappropriately or incorrectly denied.

The Department's findings are summarized below:

TABLE 3: EMERGENCY ROOM (ER) CLAIMS DENIALS

FILE TYPE	# OF FILES REVIEWED	CRITERIA	# COMPLIANT	# DEFICIENT
Non-Participating ER Claims	11	Appropriate denial	4	7
County facility	0	Appropriate	n/a	n/a
Participating ER Claims	1	Appropriate denial	0	1
Total no. of claims	12		4	8

The lack of coordination and consistency between the two entities in the use of primary diagnosis vs. admitting diagnosis to determine financial responsibility caused inappropriate multiple denials of claims before payment was eventually made. The following example provides a common scenario among the eight noncompliant claims:

An electronic claim was originally received on 12/16/04 and eventually paid on 06/17/05, six months later.

The Plan received an electronic claim (Claim #1) on 12/16/04 and denied the claim on 12/24/04. The Plan determined that this claim is the Delegate's responsibility based on the principal mental health parity diagnosis. Since no admitting diagnosis was presented, the Plan followed its guidelines to default to the principal diagnosis in the absence of an admitting diagnosis. The claim was denied, and according to the Plan, forwarded to the Delegate. When asked what date the Delegate had received the claim from the Plan, the Delegate could not produce any documentation that this claim was received and processed.

Meanwhile, a paper claim (Claim #2) for the same date of service (DOS) and provider was received by the Delegate on 02/18/05, denied on 02/25/05 based on the Plan's responsibility because of the admitting medical diagnosis, and mailed to the Plan. The Plan received the paper claim on 03/07/05 but denied it on 3/11/05 because 1) it was determined to be the Delegate's responsibility based on the principal mental health diagnosis, and 2) the claim was a duplicate of the electronic claim (Claim #1). The Plan did not follow its guideline that only when the admitting diagnosis is missing will it default to the principal. Again, the Plan mailed the claim to the Delegate. The Delegate presented no evidence that it received the claim from the Plan.

A third claim (the origin of Claim #3 is unclear, whether it was forwarded from the Delegate or whether the provider submitted another bill) was received by the Plan on 04/18/05 for the same

DOS. The Plan again denied this claim on 04/29/05 for the same two reasons cited above and again forwarded the claim to the Delegate.

A fourth claim (the origin of Claim #4 also unknown) was received by the Plan on 04/22/05, subsequently denied for the same two reasons cited for denying Claim #2 and #3 above), and again forwarded to the Delegate.

When these claims were discussed with Plan staff on 06/13/05, they agreed that these claims should not have gone back and forth between the Plan and the Delegate and should have been paid by the Plan based on the admitting diagnosis. The claim was paid on 06/17/05 with the appropriate amount of interest, shortly after the discussion between the Department and Plan staff.

Other issues:

For electronically submitted claims (EDI): Even if the claim may originally contain an admitting diagnosis, the Delegate's EDI system is not formatted to accommodate and register it when claims data is uploaded. This limitation results in unnecessary delay when the examiner will "pend" the claim because it does not have an admitting diagnosis. The Delegate is in the process of correcting this system limitation and plans to complete it in early 2006.

The Plan's claims system has been converted to a new system and is able to accommodate "admitting diagnosis" of EDI claims. A problem arises if an EDI claim with an admitting mental health diagnosis and a medical principal diagnosis is submitted initially to the Plan. The Plan will deny the claim based on the admitting diagnosis and forward the claim to the Delegate. But the Delegate's EDI system has no capability to accommodate the mental health "admitting diagnosis" initially visible to the Plan. At times the Delegate does not follow its guidelines consistently. The examiner may call the provider and obtain the admitting diagnosis or may deny the claim based on the medical "principal diagnosis."

Implications: The lack of coordination, communication, consistency, and parity between the Plan and its Delegate causes a cumbersome and unnecessary delay in the processing of legitimate claims. Because of confusing reasons for denial, providers are inclined to resubmit (at times, several times) to both the Plan and the Delegate in an effort to find the "right payor." Non-participating providers may tire of resubmitting or disputing the denial and may eventually hold the enrollee financially responsible for a benefit s/he is entitled to.

Corrective Action:

(1) The Plan shall submit a corrective action plan that addresses the issues discussed above, specifically:

- The inconsistency between Plan's and Delegate's processing guidelines;
- The lack of coordination between the Plan and the Delegate;
- The unnecessary delay in processing claims;
- The inappropriate and incorrect denial of claims; and
- The limitations of the EDI system.

The corrective action plan shall specify the start and completion dates of the related corrective activities. The Plan shall submit evidence of corrective activities, e.g., revised policies, as applicable; staff retraining, joint meetings between Plan and Delegate, communications to providers, etc.

In addition:

(2) The Plan shall develop and implement an internal audit program designed to monitor compliance with its ER claims processing policies and procedures.
(3) Specific Audit criteria shall include, but not be limited to the
   a. Total number and percentage of ER claims that qualified for automatic payment
   b. Total number and percentage of ER claims that qualified for automatic payment and were automatically paid
   c. Total number and percentage of ER claims that were referred for medical review
   d. Accuracy of medical review determination, based on statutory requirements
(4) Files selected for audit should include appealed cases as well as initial determinations.
(5) File sampling method should be proportionate to the total number of facility types (participating, county, other) from which the Plan receives ER claims. For example, if claims from county facilities account for 20 percent of the Plan's total ER claims, then 20 percent of the ER claims selected for audit should be from county facilities.
(6) The Plan shall establish an implementation date for the audit program, which should not be later than two months from the date of this Preliminary Report, and include the implementation date in its response to this Preliminary Report. Audit results should be reported to the Department within a reasonable timeframe, after the first three and six months of the implementation date.

Plan's Compliance Effort: The Plan stated in its response the following:

The Plans respectfully assert that the claims review by the Department's auditors should not have resulted in a finding of deficiency. Nevertheless, the Plans have taken action to address the concerns expressed by the Department's auditors regarding the coordination of payment of emergency room claims that include both medical and mental health services. Based upon the corrective action being taken, the Plans respectfully request that the cited deficiency be reflected as corrected on the Final Report.

The Plans acknowledge the auditor's request to improve coordination of emergency room (ER) claims involving a medical admitting diagnosis and a mental health primary diagnosis ("mixed services ER claims"). Although these claims occur infrequently, action has been taken that will correct the claims systems so that both CIGNA HealthCare and CIGNA Behavioral can accommodate and track the admitting diagnosis and assure the responsible entity processes the claims. The Plans respectfully assert that the extensive corrective action suggested by the auditors that includes an onerous internal audit program is unjustified and unnecessary.

The Plans note that the claim problem identified by the auditors resulted from a limitation in the

CIGNA HealthCare claims system referred to internally as the "legacy" system. The legacy system does not track the "admitting diagnosis" of a mixed services ER claim received via EDI (electronically). This limitation resulted in the delays identified by the auditors in processing some of the mixed services ER claims received via EDI. Again, the Plans wish to emphasize that the claims affected by the limitation represent a tiny fraction of all claims processed by the Plans.

CIGNA HealthCare is currently in the process of shutting down the legacy claim system. At the time of the focused survey, about 20 percent of the Plan's membership was tied to the legacy system. Each subsequent month, however, the Plan has been moving remaining membership to a new "end state" claims platform. By January 1, 2006, approximately 98 percent of the Plan's members will be on this new platform for the payment of claims. This "end state" system is able to recognize and accommodate "admitting diagnosis" when submitted on EDI claims, thereby eliminating resulting unnecessary delays based on the Plan's system limitation.

The Standard Operating Procedure (SOP) for the Plan's "end state" system clearly informs the CIGNA HealthCare claim examiner where to find the "admitting diagnosis" for both paper and EDI claims as follows:

> **Admitting Diagnosis vs. Primary Diagnosis**
> The admitting diagnosis code is why a patient goes in for treatment, **before** being examined.
>
> The admitting diagnosis can be found as follows:
> - Paper claims -Box #76 on the UB92.
> - EDI claims - ED1021 screen, under the Diagnosis Codes section, in the box of the first column/second row.

Going forward, if CIGNA HealthCare is the initial recipient of an "end state" claim (either EDI or paper) that has a behavioral "admitting diagnosis", the above mentioned SOP directs the examiner to deny the claim and forward to CIGNA Behavioral. If the "admitting diagnosis" is medical, then the SOP directs the examiner to pay the claim. Because the "end state" system is able to recognize the "admitting diagnosis" on EDI claims, CIGNA HealthCare will no longer need to automatically default to "principal" or "primary" diagnosis for the adjudication of claims when an "admitting diagnosis" is submitted by a provider, thereby eliminating potential coordination issues between the two plans.

If CIGNA HealthCare initially receives an EDI claim that it determines is the financial responsibility of CIGNA Behavioral, it prints out the information submitted via EDI (as a paper claim) and forwards it to CIGNA Behavioral. When CIGNA Behavioral receives one of these "hardcopy EDI" claims from CIGNA HealthCare, it follows its SOP and processes accordingly. Contrary to what is indicated in the Preliminary Report, this does not present a problem – CIGNA Behavioral's claim systems are able to capture "admitting diagnosis" for both paper and EDI claims.

An internal oversight audit of CIGNA Behavioral and CIGNA HealthCare claims payment practices has been scheduled for September 2005. The samples selected for these audits will

include ER claims, and the audits will be conducted in accordance with the Plans' established audit programs.

The Plans are confident that once membership has been fully transitioned to the end state claims system, the coordination problem that the auditors identified between CIGNA HealthCare and CIGNA Behavioral involving mixed services ER claims will not reoccur.

The Plan submitted the following document:

- SOP for Processing mixed service claims

Department's Finding Concerning Plan's Compliance Effort:

STATUS: CORRECTED

The Department finds that significant effort in ensuring compliance has been demonstrated by the plan.

With respect to the portion of the deficiency caused by the limitation of the Plan's legacy system, the Department finds that the Plan has appropriately addressed the Department's concern regarding the EDI submitted claims.

The Plan stated that an internal oversight audit of CIGNA Behavioral and CIGNA HealthCare claims payment practices has been scheduled for September 2005, that the samples selected for these audits will include ER claims, and that the audits will be conducted in accordance with the Plans' established audit programs. To demonstrate to the Department the Plan has implemented and evaluated results from the September 2005 audit, inclusive of ER Claims, the Plan must submit to the Department audit results and associated actions to correct problems, as appropriate within 30 days upon receipt of this Final Report.

SECTION IV. SURVEY CONCLUSIONS

The Department has completed its Focused Survey of the Plan. The Department will continue to monitor the Plan's compliance with the provisions of the Parity Act through its Routine Medical Surveys, which are conducted at least once every three (3) years.

The Department will develop a Summary Report that aggregates and analyzes the Parity Focused Survey results of all plans surveyed by Fall 2005. The Summary Report will be available to the plans and to the public through the Department's Public File.

A P P E N D I X A

METHODOLOGY & PARAMETERS

A. Review Methodology

The Department conducted a Focused Survey of the Plan during May 23–26, 2005, at the Delegate's offices in Glendale, California, to evaluate the Plan's compliance with Section 1374.72. The Department conducted the survey utilizing the clinical expertise of a board-certified psychiatrist, a licensed clinical social worker, and a nurse.

Survey activities included the review of plan documents, enrollee case files, and claims. The surveyors conducted interviews with officers and staff from the Plan and its Delegate. Surveyors also telephoned 50 participating providers to assess appointment availability and evaluate the providers' telephone messages with regard to the provision of emergency services. Each survey activity is described in greater detail below.

Review of Plan documents – The Department reviewed a number of additional materials to assess various aspects of Plan compliance, for example:

- Policies and procedures for all related activities
- Internal performance standards and performance reports, including minutes of meetings at which performance is reviewed and corrective action taken
- Communications that explained coverage and benefits
- Materials demonstrating continuity and coordination of care
  - Reports on inpatient admissions, office visits, and other services provided
  - Clinical practice guidelines and protocols
  - Case management program descriptions and case files
- Reports on access and availability of services
  - Number and geographic distribution of clinicians, facilities, and programs
  - Appointment availability
  - Timeliness of answering the triage and referral telephones
- Reports demonstrating the Plan's oversight of any activities performed by its Delegate

Review of enrollee utilization management and case files: Prior to the onsite visit, the Department requested logs for a number of Plan activities; e.g., utilization review, claims processing, case management, etc. From these, the Department selected samples of case files for a comprehensive review. Review focused on measures such as appropriateness of denials of services, timeliness of decision-making, and coordination of care, as well as the appropriate exchange of information among providers.

Plan staff participated in the review of utilization management files. Table 4 below displays the categories of claims reviewed and the sample sizes selected.

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TABLE 4: FILES REVIEWED

CATEGORY OF FILE	SAMPLE SIZE
Utilization Management - Medical Necessity Denials for Children with Autism or Seriously Emotionally Disturbed Children	10
Utilization Management - Medical Necessity Denials for Other Individuals	24
Utilization Management - Benefit Denials for Children with Autism or Seriously Emotionally Disturbed Children	3
Utilization Management - Benefit Denials for Other Individuals	14
Utilization Management - Denials of Non-Formulary Pharmaceuticals	3
Continuity and Coordination of Care – Case Management Files	20

Review of claims – Prior to the onsite visit, the Department requested claims listings. From these, the Department selected samples of claims for comprehensive review. Review focused on measures such as the appropriateness of denial and the accuracy of payment based on mandated parity benefits. Plan staff participated in the review of claims files. Table 5 below displays the categories of claims reviewed and the sample sizes selected.

TABLE 5: CLAIMS FILES REVIEWED

CATEGORY OF CLAIM	SAMPLE SIZE
Claims for emergency services from nonparticipating providers	11
Claims for emergency services from participating providers	1

Interviews – The Department interviewed staff from both the Plan and Delegate to augment the review of documents and obtain a comprehensive picture of Plan activities surrounding the implementation of Section 1374.72, as well as to discuss the specific files, claims, and documents the Department reviewed. The list of individual officers and staff members interviewed, along with their respective titles, may be found in Appendix C. The list of the Department's survey team members who conducted the interviews may be found in Appendix D.

B. Utilization Management File Review Parameters

The parameters assessed during the review of each file included (as appropriate to each sample type):

- Diagnoses;
- Accuracy of case categorization (parity vs. non-parity);
- Decision rendered/action taken by plan (approval or denial);
- Adequacy of clinical information obtained to support decision-making;
- Documentation of rationale supporting the decision rendered;
- Accuracy of decision based upon statutory requirements; and
- Consistency between decision and communication sent to the affected practitioner/provider and member.

C. Claims Review Parameters

The parameters assessed during the review of claims included:

- Diagnoses;
- Accuracy of claim categorization (parity vs. non-parity; participating vs. nonparticipating; and emergency vs. non-emergency);
- Adequacy of administrative and clinical information obtained to support denial decision-making;
- Appropriateness of denial;
- Documentation of referral to medical review prior to denial decision rendered;
- Accuracy of documented denial reason based upon plan policies regarding claim processing;
- Accuracy of payment based on mandated parity benefits; and
- Appropriateness and accuracy of communication sent to the affected practitioner/provider and enrollee.

A P P E N D I X B

OVERVIEW OF PLAN OPERATIONS

A. Plan Profile

Tables 6 through 8 below summarize the information submitted to the Department by the Plan and its Delegate in response to the Pre-Survey Questionnaire:

TABLE 6: PLAN PROFILE

Type of Plan	**Full Service Plan**	
Specialized Health Care Service Plan(s) or Mental Health Plan(s) (i.e., delegates) with which the Plan Contracts for Provision of any 1374.72 Services as of March 31, 2005	**Knox-Keene Licensed Behavioral Health Plan**	**Enrollees**
	CIGNA Behavioral Health of California, Inc.	270,239 (75%)
	American General	1,750 (0%)
	Compsych	544 (0%)
	HAI Magellan	1,517 (0%)
	Horizon Behavioral Health	11,317 (3%)
	Integrated Behavioral Health	312 (0%)
	Magellan Behavioral Health	2,691 (1%)
	Managed Health Network	20,062 (6%)
	Menninger Care Systems	107 (0%)
	Solutions-Value Options	1,431 (0%)
	The Holman Group	327 (0%)
	United Behavioral Health	7,062 (2%)
	Value Options	13,903 (4%)
	Other Arrangements	27,553 (8%)
	Total	**358,815**

	Product Lines	Enrollees
Number of Enrollees Covered by Mental Health Parity as of March 2005	Network HMO (Commercial and Network/FlexCare)	241,866
	Point-of-Service (Commercial and Network/FlexCare)	116,949
	Total	**358,815**

Service Area(s) *(counties, in full or in part)*	Alameda Butte Contra Costa El Dorado* Fresno Glenn Kern Kings	Los Angeles Marin Merced* Orange Placer* Riverside* Sacrament San Bernardino*	San Diego San Francisco San Joaquin San Luis Obispo San Mateo Santa Barbara Santa Clara	Santa Cruz Solano Sonoma* Stanislaus Tulare* Ventura Yolo

*Indicates a partial county

Plan Identification of Enrollees Eligible for Parity Services

Adults: Adults with parity diagnoses are identified through the diagnoses listed by the providers on claims. The claims system has been programmed not to count office visits or hospital days against the enrollees' mental health office visit and hospital day limits when a claim has a primary diagnosis that is a parity diagnoses. If a claim is submitted with multiple diagnoses, and a parity diagnosis is not the primary diagnosis on the claim, Delegate staff indicated that the claim is subject to an enrollee's benefit limitations for non-parity diagnoses.

Seriously Emotionally Disturbed Children: SED children are identified through multiple mechanisms. The parent may inform a patient advocate or care manager that the child is considered SED. The treating provider may inform a care manager that the child is SED. If the parent contacts the Delegate seeking care because the child is in crisis, the crisis team case manager may determine that the child is SED. An inpatient care manager may identify a child as SED when the child is admitted to the hospital or a structured outpatient program. Lastly, when a child has used 65% of his/her outpatient visit benefit (or after 15 office visits if the child has an unlimited mental health visit benefit), the computer system automatically sends a letter to the enrollee's provider asking the provider to contact an outpatient care manager to review the enrollee's treatment plan. At this time the outpatient care manager may determine that the child is SED and entitled to mental health parity benefits.

Once an enrollee is identified as SED, the outpatient care manager makes a notation in the care management notes and in the prior-authorization system that the child is SED. The outpatient care manager then preauthorizes visits for six months at a time, which effectively overrides the enrollee's benefit visit limit. The same mechanism is used to override hospital day benefit limitations.

TABLE 7: MENTAL HEALTH PROVIDER NETWORK

Practitioners That Treat Adults	Number in the Network
Psychiatrists	495
Doctoral-level psychologists	710
Mental health nurse practitioners with furnishing numbers	12
Licensed Marriage and Family Therapists (MFT)	927
Licensed Clinical Social Workers (LCSW)	455
LMFC, RN, CNS	26
Total	**2,625**

Practitioners That Treat Children and Adolescents	Number in the Network
Psychiatrists	111
Doctoral-level psychologists	236
Mental health nurse practitioners with furnishing numbers	1
LMFTs	269
LCSWs	152
LMFCs, RN	4
Total	**773**

Programs and Institutional Providers That Treat Adults	Number in the Network
Acute inpatient units—voluntary admissions	77
Acute inpatient units—involuntary admissions	77
Crisis treatment centers/programs	2
Intensive outpatient treatment programs/partial hospitalization	131
Residential treatment programs	59
Eating disorder programs	13

Programs and Institutional Providers That Treat Children and Adolescents	Number in the Network
Acute inpatient units—voluntary admissions	26
Acute inpatient units—involuntary admissions	26
Crisis treatment centers/programs	1
Intensive outpatient treatment programs/partial hospitalization	64
Residential treatment programs	13
Eating disorder programs	8

TABLE 8: ACCESS AND AVAILABILITY STANDARDS

Provider Availability Standards				
Type of Practitioner	**Ratio of Practitioners to Enrollees**	**Geographic Availability**		**Percent of Open Practices**
		Urban	**Rural**	
Psychiatrists	1 MD per 1500 enrollees (Goal=100%)	1 MD in 15 Miles/30 Minutes (Goal=95%)	1 MD in 25 Miles (Goal=85%)	No established standard
Doctoral-level psychologists	1 non-MD per 800 enrollees Goal=100%)	1 Non-MD in 15 Miles/30 Minutes (Goal=98%)	1 Non-MD in 25 Miles (Goal=90%)	
Mental health nurse practitioners with furnishing numbers				
Master's prepared therapists				

Appointment Availability Standards	
Type of Services	**Standard**
Emergency	Life Threatening: Immediately Non-Life Threatening: Within 6 hours
Urgent Care	Within 48 Hours
Initial Post-hospitalization Follow-up Visit	Within 7 Days
Routine Visit	Within 10 Days
After-Hours Care	24 Hours/Day

Telephone Responsiveness Standards	
Telephone Availability	**Standard**
Triage and Referral	< 30 Seconds
Triage and Referral Abandonment Rate	< 5%
Member Services Average Speed of Answer	< 30 Seconds
Member Services Abandonment Rate	< 5%

B. Overview of Programs

Table 9 below presents a brief overview of the Plan's operations in each of the four program areas examined during the Department's focused survey.

TABLE 9: OVERVIEW OF PROGRAMS

PROGRAM	DESCRIPTION
ACCESS AND AVAILABILITY	• The Plan's marketing materials and combined Health Care Handbook and Group Service Agreement accurately present coverage for parity diagnoses and conditions when mental health coverage is discussed. • Benefits for Severe Mental Illness and for Severe Emotional Disturbance of a Child are described as being identical to benefits for medical conditions. All of the nine required diagnoses are included. However, the description of Serious Emotional Disturbances of a child includes the initial mandated language, but refers the reader to WIC 5600.3(a)(2) without actually including the complete language in the text • Effective July 1, 2003, the Delegate changed its utilization management system to simplify access for enrollees and simplify utilization management processes for participating providers. At that time, CIGNA abolished requirements for prior-authorization and submission of treatment plans for all in-Plan routine outpatient care. This includes office visits and up to four hours of psychological testing. The only exception to this is if a payor requires prior-authorization. Thus, enrollees can access outpatient care directly without contacting the Delegate. • Enrollees can find a participating mental provider by: ▪ Calling the CIGNA Personal Advocate Team; ▪ Calling an automated voice response telephone system; and/or ▪ Querying the CIGNA Behavioral Health Web site. • The Delegate has a well-articulated plan for crisis stabilization

ACCESS AND AVAILABILITY	services, which are defined as services designed to "…assess, stabilize and proactively identify the most appropriate level of care for the participant at that time." A separate crisis team handles these cases for assessment and referral to a provider, and tracks the amount of time to a completed evaluation monitored by the QI program. A subset of the provider network is credentialed to provide these services, and these providers are reimbursed a higher rate for providing crisis services. Extended duration appointments are available when needed to stabilize a situation. • The Delegate maintains a telephone number during normal business hours to respond to enrollee requests for information about mental health benefits. All calls from California members are routed through the same queue at the Delegate's Glendale office. Calls are answered by the Delegate's Personal Advocate Team (PAT) from 7 a.m. until 9 p.m. From 9 p.m. until 7 a.m., all calls are routed to the Delegate's national corporate office in Minnesota. • A licensed care manager is available in the Glendale office at all hours the PAT telephone line is open to assist with higher acuity callers. Licensed supervisory staff members from the Glendale office are available by pager after-hours to assist the national call center with questions specific to California members. • Enrollees with eating disorders and those with autism are followed by care managers. Enrollees that have eating disorders are usually treated in IOP programs unless a clinical reason necessitates inpatient care. The Delegate has increased the number of IOP programs in its network since the implementation of mental health parity. • The Delegate has standards for the number and geographic availability of psychiatrists and other providers (see above). The Delegate measures its network against these standards annually and reports that it met is performance goals for 2003 and 2004. It also monitors enrollee complaints about access to services regularly and measures enrollee satisfaction with availability of services annually.
UTILIZATION MANAGEMENT	• The Delegate maintains objective, evidence-based, risk-based rather than diagnosis-based, and consistent utilization management criteria described in *CIGNA Behavioral Health Level of Care Guidelines*. The Delegate treats parity and non-parity diagnoses in a similar fashion. The level of care criteria are developed by the Delegate on a national level with the involvement of practicing providers including those from California. • Under the Delegate's "Care Advocacy" program, launched in 2003, "for routine care, neither pre-authorization, nor treatment plan submissions are required." Any enrollee may start routine outpatient treatment with any outpatient network provider with no requirement for preauthorization or concurrent authorization until specific milestones are reached. After an enrollee starts treatment, the Delegate's information system automatically reviews all provider claims so as to trigger contact between provider and care manager under specific circumstances and at specific points in the course of treatment. These automatic triggers are based on a variety of factors

UTILIZATION MANAGEMENT *(Continued)*	that define sets of "rules," and the resulting provider case reviews are termed "AFLUP's" (Automatic Follow-ups). • In the absence of a denial stemming from a concurrent review triggered by the Delegate's rules, payment of claims is governed by the primary diagnosis on the claim. A parity diagnosis results in routine outpatient visits paid as a parity benefit until such time as a rules triggered review might lead to a denial of further treatment. If a claim is submitted with multiple diagnoses, and an enrollee's parity diagnosis is not the primary diagnosis on the claim, Delegate staff stated that the claim will be treated as one subject to an enrollee's benefit limitations for non-parity diagnoses. • All outpatient cases, regardless of other circumstance-based rules they might trigger, are eventually affected by rules based purely on the number of treatment contacts for which a claim has been submitted. When 65 percent of an enrollee's yearly benefits have been exhausted (for a non-parity or non-SED claim), a letter is sent to the provider asking that he or she contact a care manager to review the treatment plan. Alternatively, in a parity diagnosis or known SED case, the rule would trigger a similar letter after the 25th visit. • Additionally, a variety of "rules" are defined by various factors in combination, including number of sessions within a calendar year, age of patient, and diagnosis. These latter rules trigger care manager calls rather than a letter to the provider. Examples include the situation of any child with an eating disorder diagnosis, or any enrollee with major depression that has not had a psychotropic medication prescribed after 12 visits. The result of a rules-triggered case review can be authorization of a specific number of additional sessions, followed by another concurrent review. • The care manager contacts generated by AFLUPs allow the Delegate to review the progress of "routine" care to assure that treatment does not deviate significantly from established evidence-based clinical guidelines or the Delegate's level of care guidelines. The care manager obtains comprehensive clinical data. If continued treatment is questionable, the case is referred to a board certified psychiatrist or licensed psychologist. At the peer reviewer's

UTILIZATION MANAGEMENT *(Continued)*	• discretion a review consultation may be held with the provider, and further care may be denied. Only a psychiatrist may deny services requested by a psychiatrist or addictionologist. • Prior authorization is required for non-emergency hospitalization, partial hospitalization, intensive outpatient programs, electro-convulsive therapy, and psychological testing beyond an initial four hours of testing. • Inpatient care managers perform concurrent telephone reviews every several days. At the time of an initial telephone contact, any emergency admission that was not preauthorized is also retroactively reviewed. • Enrollees with an autism spectrum diagnosis are provided services on the same basis as any enrollee with a parity diagnosis. ▪ An enrollee with autism can access outpatient treatment with a network provider and routine outpatient care is paid until a rule triggers an AFLUP, which leads to UM review. At that time, an outpatient care manager calls the provider to obtain clinical information. The care manager then either authorizes further sessions, or if the care manager questions the treatment plan, then refers the case to peer review. ▪ If an enrollee calls the Delegate requesting information about obtaining an evaluation for autism, the patient advocate helps the parent identify a network child psychiatrist or other therapist specializing in autism. Once that evaluation generates a diagnosis of autism or pervasive developmental disorder, the enrollee qualifies for parity benefits. ▪ The Delegate does not cover autism services typically rendered by non-licensed personnel, such as applied behavioral analysis. ▪ The Delegate is not responsible for arranging or paying for speech and language therapy or occupational therapy for enrollees with autism. If the enrollee receives medical services through a capitated medical group, as do approximately 90 percent of the Plan's enrollees, the medical group is responsible for these services. The Plan's UM department authorizes these services for the remaining 10 percent of enrollees. ▪ The Department discussed the process for enrollees obtaining authorization for speech and language therapy and occupational therapy services with the Plan Medical Director, the Plan Director of Health Services, and a Plan attorney.

UTILIZATION MANAGEMENT *(Continued)*	• The attorney stated that the Plan was not required to provide speech and language therapy services and occupational therapy services available through Regional Centers and school systems because of the following exclusions in the Plan's EOC: 1) "Care required by state or federal law to be supplied by a public school system or school district;" and "Care for health conditions that are required by state or local law to be treated in a public facility…." • The Plan Medical Director and Director of Health Services stated that the Plan first requires the enrollee to seek services through the Regional Center and/or school system. However, if parents report that they cannot obtain all required services through the Regional Center and/or school system, the Plan will provide these services. The Plan does not require that the parent provide documentation that the services are not available. • The Plan Medical Director stated that he believed that the capitated medical groups also provide these services when the services were not available, in whole or in part, through the Regional Center and/or school system.
CONTINUITY AND COORDINATION OF CARE	• The Delegate has four types of care management to facilitate continuity and coordination of care: ▪ Outpatient care management, which is principally utilization for enrollees identified by the AFLUPs; ▪ Inpatient care management, which focuses on inpatient utilization management and transitions to lower levels of care at the time of discharge; ▪ Intensive care management for enrollees identified as having a high risk of poor outcomes, based on severity of illness, diagnosis, frequency of hospitalization, and/or vulnerability for relapse; and ▪ Crisis care management for enrollees identified by a triage clinician as having symptoms of mental illness or substance abuse crisis that interfere with their ability to carry out daily activities, and who are thus in need of immediate outpatient or inpatient services. • The Delegate facilitates communication between and among mental health providers in the following ways: ▪ The Delegate's inpatient care management staff interface with hospital staff, attending physicians, and staff of other programs/levels of care used as part of an enrollee's treatment plan to facilitate appropriate and timely cross communication for comprehensive level of care treatment planning. ▪ Delegate inpatient care management staff members facilitate discharge planning to ensure enrollees have timely access to follow-up care as they transition from an intensive level of care to a lower level of care, including outpatient services. ▪ The Delegate's expectations for mental health providers to share information and coordinate care are described in the

CONTINUITY AND COORDINATION OF CARE ***(Continued)***	*Provider Guide*. ▪ Care management protocols within the Care Advocacy Program define which routine outpatient cases require the Delegate's staff to assess whether the provider is coordinating care with other providers involved in the enrollee's care and actively manage individual cases needing intensive coordination between levels of care or between treating providers. • The Delegate has a policy and procedure that requires the following communication between mental health providers and primary care providers (PCP): ▪ The behavioral health provider asks the enrollee to sign a consent form for the release of confidential information to permit exchange of clinical information between the behavioral health provider with the PCP; ▪ The Delegate expects mental providers that obtain consent to communicate with the PCP within seven business days of the date of assessment and share the following information: • Date of initial assessment visit, diagnosis, initial treatment plan, medications, and diagnostic tests; • Whether the enrollee has initiated treatment; • Clinically significant changes in the enrollee's condition; and • Follow-up recommendations. • During the care management intake process, the enrollee is screened for medical problems, medications, and identification of the prescribing provider. • The Delegate and Plan co-manage enrollees who have both medical and mental care needs. This is done through care manager to care manager communication and through more structured clinical rounds on inpatients and outpatients. These rounds focus on medications, diagnostics, physician-to-physician consultations, and co-morbid medical issues. • The Delegate participates in the Plan's disease management programs that are part of the Plan's Well-Aware Program for Better Health. The disease management portion of the program is provided by American Healthways staff members who screen enrollees in the cardiac, diabetes, low back pain, and asthma programs for depression and refer those that screen positive to the Delegate. • The Department reviewed the following 20 care management case files: five inpatient; five outpatient, including two autism; five intensive inpatient, five intensive, all of which were for enrollees with multiple inpatient admissions; and five crisis care.

CONTINUITY AND COORDINATION OF CARE ***(Continued)***	The Delegate demonstrated timely and comprehensive communication between and among the enrollees' mental health providers and between enrollees' medical and mental health providers. • The Plan and the Delegate have collaborated since 1999 on the adoption and dissemination of a depression clinical practice guideline available on the provider portion of both the Delegate's and Plan's Web sites. The Plan and Delegate mail flyers to providers periodically to remind them that the guideline is available on the Web site. • The Plan measures performance against the depression guideline using the HEDIS Anti-Depressant Usage metrics. In 2004, the Plan implemented the following interventions to improve adherence to the depression guideline: ▪ Educated enrollees on symptoms and treatment of depression; ▪ Educated providers (behavioral and primary care physicians) on the depression practice guideline; and ▪ Gave high-volume prescribing providers data regarding their prescribing patterns. • The Delegate has also developed and disseminated an attention-deficit-hyperactivity disorder preventive health guideline.
DELEGATION	• A clear written contract delineates delegated responsibilities, and ample operational evidence documents close Plan scrutiny of the Delegate's performance in all required areas, including continuity and coordination of care. ▪ The "Service Agreement" of July 25, 1990, between the predecessor organizations to the current Plan and Delegate, as amended 12 times over the years, exhibits compliance with all Delegation requirements. ▪ Amendments Nine and Ten, dated July 1, 2000, and November 1, 2000, respectively, amended the Delegate's responsibilities to clearly define expectations of parity mental health benefits as defined by Section1374.72. • The delegation Service Agreement is out-of-date with respect to the responsibility for the appeals process. The now outdated assignment of appeals responsibility to the Plan has not been revised. In fact, the Delegate has been responsible for appeals for the last several years.

A P P E N D I X C

LIST OF STAFF INTERVIEWED

The following are the key Plan officers and staff who participated in the onsite survey at the Delegate's administrative office during May 23–26, 2005.

CIGNA HEALTHCARE OF CALIFORNIA, INC.	
Name	**Title**
William Jameson	Chief Counsel
Susan Mitchell	Assistant Vice President, Quality Management
Michelle Geller, RN	Quality Management Coordinator
George Price	Compliance Officer
Nancy Ho, PharmD	Pharmacy Director
Jeffrey Hankoff, MD	Medical Director
Jan Ogle, RN	Director of Health Services
Todd Ebersole, Esq	Counsel

CIGNA BEHAVIORAL HEALTH, INC.	
Name	**Title**
Susan Urbanski	President
Nick Osterman	Regional Director
Craig Coenson, MD	Interim Medical Director
Ken Carter	Counsel
Sherry Orenstein-Estrada	Professional Relations Manager
JoAnn Rowe	Personal Advocate Team Leader
LisaMarie Golden	Operations Manager
LiAnn Hathaway	Quality Manager
Mia Hamlin, LMFT	Outpatient Team Leader
Dayle Sigmund	Assistant Regional Director
Andrew Sway, LMFT	Triage Team Leader
James Hall, LCSW	Inpatient Team Leader
David Backhaus, LMFT	Outpatient Care Manager
Susan Benjaminsen, MA, LMFT	Lead Clinician, Outpatient Team
Carol Rosenthal, MA, LMFT	Care Manager, Outpatient Team

A P P E N D I X D

LIST OF SURVEYORS

The Department's Survey Team consisted of the following persons:

DEPARTMENT OF MANAGED HEALTH CARE REPRESENTATIVES	
Name	**Title**
Saralea Altman	Senior Health Plan Analyst
Tom Gilevich	Counsel, HMO Help Center

MANAGED HEALTHCARE UNLIMITED, INC. REPRESENTATIVES	
Name	**Title**
Rose Leidl, RN	Contract Manager
Bernice Young	Program Director
Ruth Martin, MPH, MBA	Parity Survey Team Leader
Marshall Lewis, MD	Utilization Management and Delegation Management Surveyor
Nikki Cavalier, LCSW, CPHQ	Access and Availability Surveyor
Patricia Nelson, RN, MD, CS, CPHQ	Continuity and Coordination of Care Surveyor
Linda Woodall	Emergency Room Claims Surveyor

A P P E N D I X E

STATUTES AND REGULATIONS APPLICABLE TO THE IDENTIFIED DEFICIENCES

A. ACCESS AND AVAILABILITY OF SERVICES

Deficiency 1: The Plan, via the Delegate personal advocates, does not clearly present the distinction and benefit differences between parity and non-parity conditions to enrollees who contact the Delegate for benefit information or to access services.[[Rule 1300.67.2(g)]

Citation:
Rule 1300.67.2(g)
A section of the health education program shall be designated to inform enrollees regarding accessibility of service in accordance with the need of such enrollees for such information regarding the plan or area.

B. UTILIZATION MANAGEMENT

Deficiency 2: The Plan does not consistently include the direct telephone number or extension of the mental health professional who made the medical necessity denial determination in the denial decision notification that the Plan sends to the requesting provider. The Plan also does not include the name of the pharmacist or mental health professional who made the formulary exception denial determination in the denial decision notification that the Plan sends to the requesting provider. [Section 1367.01(h)(4)]

Citation:
Section 1376.01(h)(4)
…Any written communication to a physician or other health care provider of a denial, delay, or modification of a request shall include the name and telephone number of the health care professional responsible for the denial, delay, or modification. The telephone number provided shall be a direct number or an extension, to allow the physician or health care provider easily to contact the professional responsible for the denial, delay, or modification…

Deficiency 3: The Plan incorrectly and inappropriately denies payment for emergency claims. [Section 1371.4(b) and (c)]

Citation:
Section 1371.4 (b) and (c)
(b) A health care service plan shall reimburse providers for emergency services and care provided to its enrollees, until the care results in stabilization of the enrollee, except as provided in subdivision (c). As long as federal or state law requires that emergency services and care be provided without first questioning the patient's ability to pay, a health care service plan shall not require a provider to obtain authorization prior to the provision of emergency services and care necessary to stabilize the enrollee's emergency medical condition.

(c) Payment for emergency services and care may be denied only if the health care service plan reasonably determines that the emergency services and care were never performed; provided that a health care service plan may deny reimbursement to a provider for a medical screening examination in cases when the plan enrollee did not require emergency services and care and the enrollee reasonably should have known that an emergency did not exist. A health care service plan may require prior authorization as a prerequisite for payment for necessary medical care following stabilization of an emergency medical condition.

A P P E N D I X F

LIST OF ACRONYMS

Acronyms	Definition
AFLUPs	Automatic Follow-ups
CAP	Corrective Action Plan
DMH	Department of Mental Health
DOI	Department of Insurance
EOC	Evidence of Coverage
ER	Emergency Room
HMO	Health Maintenance Organization
ICD-9	International Classification of Diseases 9th Revision Clinical Modification
LCSW	Licensed Clinical Social Worker
LMFT	Licensed Marriage and Family Therapist
MSA	Metropolitan Statistical Area
PCP	Primary Care Physician
PMG	Primary Medical Group
UM	Utilization Management

A P P E N D I X G

THE SURVEY PROCESS AND INSTRUCTIONS FOR THE PLAN'S CORRECTIVE ACTIONS AND RESPONSES

The following provides detail on the required survey activities and the order in which they are undertaken by the Department as well as instructions on how plans must institute corrective actions and prepare their responses to the Preliminary Report and the Final Report. Table X summarizes the survey activities and the corresponding timeframes.

TABLE 10: FOCUSED SURVEY PROCESS

SURVEY ACTIVITY	TIMEFRAME
Focused Survey Onsite Visit Conducted	As needed
Preliminary Report due from the Department to the Plan	30–50 calendar days from the last day of the onsite visit
Response due from Plan to the Department [Section 1380(h)(2)] *(Include evidence that each deficiency has been fully corrected)*	45 calendar days from date of receipt of Focused Survey Preliminary Report
Final Report due from the Department to the Plan	Within 170 days from the last day of the onsite visit
Response from Plan to Department on any matters in Final Report	Within 10 calendar days from receipt of Final Report. Response is included in Public File with Final Report
Final Report due from Department to the Public File [Section 1380(h)(1)]	Within 180 days from the last day of the onsite visit

Survey Preparation

The Department conducts a Focused Survey of a licensed health care service plan on an adhoc basis in order to evaluate a plan's compliance with certain Knox-Keene requirements and address specific issues identified by the Department. This Focused Survey specifically evaluates a plan's compliance with Section 1374.72.

Prior to the visit, the Department supplies the Plan with a Pre-Onsite Visit Questionnaire and a list of materials that the Plan is required to submit to the Department prior to the onsite visit. These materials are reviewed by the survey team to provide them with an overview of plan operations, policies, and procedures in preparation for the visit. The Plan is also advised of the materials (e.g., case files, reports) the surveyors will review during the onsite visit so that these will be readily available for the survey team.

Onsite Visit

During the onsite visit, the survey team reviews materials and conducts interviews with Plan staff and possibly with providers.

Preliminary Report

Specific to this Mental Health Parity Focused Survey, the Department provides the Plan with a Preliminary Report within 40 days of the onsite visit. The Preliminary Report details the Department's survey findings and the required corrective actions.

Plan's Response to the Preliminary Report

In accordance with Section 1380(h)(2), the Plan has 45 calendar days from the date of receipt of the Preliminary Report to file a written response. Preliminary and Final Reports are "deficiency-based" reports; therefore, only specific areas found by the Department to be in need of improvement are included in these Reports. Omission of other areas of the Plan's performance from the reports does not necessarily mean that the Plan is in compliance with the Knox-Keene Act. The Department may not have surveyed these other areas or may not have obtained sufficient information to form a conclusion about the Plan's performance in other areas.

All deficiencies cited in the Preliminary Report require corrective actions by the Plan. The Department specifies corrective actions in cases where factual findings of a deficiency constitute a violation of the Knox-Keene Act. The Plan must implement all required actions in the manner prescribed by the Department. The Plan must submit evidence that the required actions have been or are being implemented when the Plan submits its 45-day response.

The Plan's response should include the following information for each deficiency identified in the Preliminary Report:

(1) The Plan's response to the Department's findings of deficiencies;

(2) The Plan's response to the Department's specified corrective actions, which include a corrective action plan (CAP);

(3) Whether the CAP is fully implemented at the time of the Plan's response, and if so, documents or other evidence provided by the Plan that the deficiencies have been corrected; and

(4) Evidence submitted by the Plan that remedial action has been initiated and is on the way to achieving compliance if the CAP cannot be fully implemented by the time the Plan submits its response. Please include a timeline for implementing the corrective action and a full description of the evidence the Plan will submit for the Department's follow-up review that will show the deficiency has been fully corrected.

In addition to requiring corrective actions, the Department may take other actions with regard to violations, including enforcement actions.

The Plan may request that designated portions of the response be maintained as confidential, pursuant to Section 1380(g)(6). If the Plan's response indicates that the development and implementation of corrective actions will not be completed by the time the Plan files its 45-day response, the Plan should file any policies and procedures required for implementation as Plan amendments and/or material modifications pursuant to Section 1352 and Rule 1300.52.4. If this situation occurs, the Plan should file both a clean and redline version of revised policies and procedures through the Department's Web portal. The Plan is to clearly note in its response to the Preliminary Report, which is to be submitted via e-mail and hard copy to the Department, that the revised policies and procedures have been submitted to the Department via the Web portal. The Plan is not to submit its entire response to the Preliminary Report through the Department's Web portal, only those documents that meet the criteria as stated in Section 1352 and Rule 1300.52.4.

Final Report and Summary Report

Upon review of the Plan's response to the Preliminary Report, the Department will publish a Final Report that will contain the survey findings as they were reported in the Preliminary Report, a summary of the Plan's response, and the Department's determination concerning the adequacy of the Plan's response. Please note that the Plan's failure to correct deficiencies identified in the Final Report may be grounds for disciplinary action as provided by Health & Safety Code Section 1380(i)(1). The Final Report will first be issued to the Plan, followed by a copy to the public file. The Final Report will be issued to the public file not more than 180 days from the conclusion of the onsite survey.

The Department will also issue a Summary of the Final Report to the public file at the same time it makes the Final Report available to the public. One copy of the Summary Report is also available free of charge to the public by mail. Additional copies of the Summary Report and copies of the entire Final Report and the Plan's response can be obtained from the Department at cost.

The Plan may submit additional responses to the Final Report and the Summary Report at any time before or after the reports are issued.